CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS (STCs)

NUMBER:	21-W-00011/5 and 11-W-00159/5
TITLE:	KidCare Parent Coverage Demonstration
AWARDEE:	Illinois Department of Public Aid

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I. PREFACE

The following are Special Terms and Conditions for the Illinois KidCare Parent Coverage Program, a Medicaid and State Children's Health Insurance Program Section 1115 demonstration. The Special Terms and Conditions have been arranged into the following subject areas: General Conditions for Approval, General Reporting Requirements, Legislation, Eligibility and Enrollment, Benefits, Cost Sharing, Program Design, Operational Protocol, Monitoring, Title XIX Financial Requirements, Monitoring Budget Neutrality, and Title XXI Financial Requirements.

Amendment requests, correspondence, documents, reports, and other materials that are submitted for review or approval shall be directed to the Centers for Medicare & Medicaid Services (CMS) Central Office Project Officer and the Associate Regional Administrator at the addresses shown on the award letter.

The State agrees that it will comply with all applicable Federal statutes relating to Nondiscrimination. These include, but are not limited to: the Americans with Disabilities Act, title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

II. GENERAL PROGRAM CONDITIONS

1. **Pre-Implementation Requirements.** All Special Terms and Conditions prefaced with an asterisk (*) contain requirements that must be approved by CMS prior to the implementation date for the demonstration. No Federal Financial participation (FFP) will be provided for section 1115 program demonstration eligibles, including participants in the KidCare Rebate, ICHIP, and Hemophilia programs, as defined in the State's demonstration application, until CMS has approved these requirements. FFP will be available for such activities as project development and implementation, compliance with Special Terms and Conditions, and the readiness review. Unless otherwise specified where the state is required to obtain CMS approval of a submission, CMS will make every effort to respond to the submission in writing within 45 days of receipt of the submission. The CMS and the State will make every effort to ensure that each submission is approved within 60 days from the date of CMS's receipt of the original submission.

2. **Definitions.** For purposes of the Special Terms and Conditions, the following definitions apply.
    a. "Implementation date" is defined as the first date on which coverage to expansion parents is available. Federal financial participation (FFP) for the Illinois Comprehensive Health Insurance Program (ICHIP), Rebate, and Hemophilia programs is not available until the implementation date. CMS must approve in writing the state's proposed implementation date.

b. "KidCare Parent Coverage demonstration eligibles" is defined as parents of children eligible by all factors other than financial factors under Medicaid and SCHIP with net incomes from the MANG standard and up to and including 185 percent of the Federal Poverty Level (FPL) (who are not otherwise eligible for Medicaid or SCHIP through the respective state plans, and who are only covered by Medicaid or SCHIP by virtue of the section 1115 demonstration). The definition of "parents" will be the same as that used in the state's title XIX plan and will include "specified relatives."
c. "Mandatory" refers to those eligibility groups that a state must cover in its Medicaid State Plan, as specified in Section 1902(a)(10) and described at 42 CFR Part 435, Subpart B.
d. "Optional" refers to eligibility groups that can be covered under a Medicaid or SCHIP State Plan, i.e., those that do not require a section 1115 demonstration to receive coverage and who are not eligible as a mandatory population. The Medicaid and optional groups affected by this demonstration are non-mandatory parents and titles XIX and XXI children who are given the option to enroll in premium assistance.
e. "ICHIP program participants" are defined as participants in the Illinois Comprehensive Health Insurance Program with net incomes from 0 percent and up to and including 185 percent of the Federal Poverty Level (FPL) who are uninsurable and, by definition, do not have coverage under a group health plan or health insurance coverage as defined in section 2791 of the Public Health Service Act and are not eligible for Medicaid. No FFP is available for any members of this group who have Medicare or other insurance.
f. "Rebate program participants" are defined as participants who choose employer sponsored insurance or private insurance in lieu of direct coverage. This includes children with net incomes over 133 percent and at or below 185 percent of the Federal poverty level (FPL). It also includes children and parents who are eligible for optional Medicaid coverage and parents who are newly eligible as a result of this waiver.
g. "Hemophilia program participants" are defined as participants in the state Hemophilia program with net incomes from 0 percent and up to and including 185 percent of the Federal poverty level (FPL) who have been evaluated at a Hemophilia Center as having a diagnosis of hemophilia and who do not have coverage under a group health plan or health insurance coverage as defined in section 2791 of the Public Health Service Act and are not eligible for Medicaid. No FFP is available for any members of this group who have Medicare or other insurance.

3. **Adequacy of Infrastructure.** The State shall ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing limits; and reporting on financial and other issues.

4. *** Public Notice and Consultation.** The State will continue to comply, as demonstrated by previous documentation, with the public notice requirements published in the September 27, 1994 edition of the Federal Register, and the tribal consultation requirements issued via letter by CMS on July 17, 2001. In the event the state conducts additional consultation activities consistent with these requirements prior to the implementation, documentation of these activities will be provided to CMS.

5. *** Preparation of Operational Protocol.** Prior to service delivery under this demonstration, the State must prepare and CMS must approve an Operational Protocol document that represents all policies and operating procedures applicable to this demonstration. The required content of the Operational Protocol is outlined in Section IX of these Special Terms and Conditions.

6. **Extension or Phase-out Plan.** No later than 12 months prior to the expiration of the demonstration, the State must notify CMS whether it plans to request an extension of the demonstration. Requests for extensions will be due no later than one year prior to the expiration of the demonstration. If the state does not intend to request an extension, it must submit to CMS a phase-out plan no later than one year prior to the expiration of the demonstration. The phase-out plan is subject to CMS review and approval.

7. **Enrollment Limitation During the Last Six Months.** If the demonstration has not been extended, no new enrollment of individuals eligible solely on the basis of the demonstration is permitted during the last six months of the demonstration.

8. **Cooperation with Federal Evaluators.** Should CMS undertake an evaluation of the demonstration, the State must fully cooperate with Federal evaluators and their contractors' efforts to conduct an independent federally funded evaluation of the demonstration program.

9. **Matching of State-funded programs**. The demonstration increases the amount and scope of publicly funded health care services in the state. States must demonstrate that the annual combined amount of state funds expended for the KidCare Rebate, ICHIP, and Hemophilia programs will be maintained or increased above the SFY 2002 level during the operation of the demonstration. The maintenance of effort will be calculated over the operation of the waiver, i.e., the state must demonstrate that total state expenditures over the five years of the demonstration are equal to or exceed the total amount the state would have spent had the state made payments at the SY2002 expenditure level annually in absence of the demonstration. State expenditures for the parent expansion (new coverage under the waiver) will count toward meeting the maintenance of effort requirement. Expenditures related to individuals within the approved income eligibility levels in the KidCare Rebate, ICHIP, and Hemophilia programs are eligible for federal matching funds through this demonstration (with the exception of ICHIP and Hemophilia participants who have Medicare or other insurance). No other current or previous state-funded program is

eligible for Federal matching funds. No Federal matching for expenditures for these programs will take effect until the implementation date.

10. **CMS Right to Terminate or Suspend.** The CMS may suspend or terminate this project in whole or in part at any time before the date of expiration, whenever it determines that the state has materially failed to comply with the terms of the project. The CMS will promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date. The State waives none of its rights under 42 CFR 430, Grants to States for Medical Assistance Programs, to challenge CMS's finding that the state materially failed to comply. The CMS reserves the right to deny pending waiver requests or withdraw waivers at any time if it determines that granting or continuing the waivers would no longer be in the public interest. Subsequent to the release of this approval letter and special terms and conditions, CMS does not anticipate changes to the Illinois State Medicaid Plan, in terms of reduced coverage groups or reduced benefits, as a means of providing savings to cover individuals under the demonstration. Such changes could affect the continuation of the demonstration. If the project is terminated or any relevant waivers withdrawn, CMS will be liable for only normal close-out costs.

11. State Right to Terminate or Suspend. The State may suspend or terminate this demonstration in whole or in part at any time before the date of expiration. The State must promptly notify CMS in writing of the reasons for the suspension or termination, together with the effective date. If the project is terminated or any relevant waivers suspended by the state, CMS will be liable for only normal close-out costs.

III. GENERAL REPORTING REQUIREMENTS

1. **Quarterly Progress Reports.** No later than 60 days after the end of each quarter, the State must submit progress reports. CMS will provide the format for these reports in consultation with the state. These reports must include information on operational and policy issues appropriate to the state's program design. It must also include information on any issues which arise in conjunction with the premium assistance portion of the program for Medicaid and SCHIP eligibles, including but not limited to, access to services not covered in the enrollee's plan, transfers to direct state coverage due to cost sharing and other concerns, and member months (see Attachment A, item 3.a). The report must also include proposals for addressing any problems identified in each report. The State will also include a separate section to report on progress toward agreed-upon goals for reducing the rate of uninsurance. From data that are readily available, the State will monitor the private insurance market (e.g., changes in employer contribution levels (if possible, among employers with low-income populations), trends in sources of insurance, etc.) and other related information in order to provide a context for interpreting progress toward reducing uninsurance. The State will also continue to monitor substitution of coverage (i.e., participants dropping private coverage) and the number of participants that enroll in group health plans versus

individual coverage. The State must include a discussion of the specific content of these reports in the Operational Protocol (see Section IX).

2. **Quarterly Enrollment Reports**. Each quarter the State will provide CMS with an enrollment report by demonstration population showing end of quarter actual and ever enrolled figures.

3. **Monitoring Calls.** CMS and the State will hold monthly monitoring calls to discuss issues associated with the implementation and operation of the demonstration.

4. **Annual Reports.** The State must submit a draft annual report documenting accomplishments, including project status, including a budget update; quantitative and any case study findings; policy and administrative difficulties; and progress on conducting the demonstration evaluation, including results of data collection and analysis of data to test the research hypotheses no later than six months after the end of its operational year. Within 30 days of receipt of comments from CMS, the State shall submit a final annual report. The State must include a discussion of the specific content of these reports in the Operational Protocol (see Section IX).

5. **Final Report.** No later than 3 months after the end of the demonstration, a draft final report must be submitted to CMS for comments. CMS's comments shall be taken into consideration by the state for incorporation into the final report. CMS's document *Author's Guidelines: Grants and Contracts Final Reports* is available to the state upon request. The final report is due no later than 90 days after the receipt of CMS's comments.

IV. LEGISLATION

1. **Changes in the Enforcement of Laws, Regulations, and Policy Statements.** All requirements of the Medicaid and SCHIP programs expressed in laws, regulations, and policy statements, not expressly waived or identified as not applicable in the award letter of which these Special Terms and Conditions are a part, will apply to the demonstration. The State must come into compliance with the changes in the enforcement of Medicaid laws, regulations, and policy statements that would have affected state spending in the absence of the demonstration. To the extent that these changes would affect State Medicaid spending in the absence of the waiver, in ways not explicitly anticipated in this agreement, CMS, in consultation with the state, will incorporate such effects into a modified budget limit for the Demonstration. The modified budget neutrality limit would be effective upon enforcement of the law, regulation, or policy statement. If the law, regulation, or policy statement cannot be linked specifically with program elements of the demonstration (e.g., all disallowances involving provider taxes or donations), the State must submit its methodology for complying with the change to CMS for approval. The methodology must be

consistent with Federal law and in accordance with Federal projections of the budgetary effects of the new law. Should CMS and the state, working in good faith to ensure state flexibility, fail to develop within 90 days of the effective date of the change, a methodology to revise the without waiver baseline that is consistent with Federal law and in accordance with Federal budgetary projections, a reduction in Federal payments will be made according to the method applied in non-demonstration states.

2. **Changes in Medicaid or SCHIP Law.** The State must, within the time frame specified in law, come into compliance with any changes in Federal law affecting the Medicaid or SCHIP program that occur after the demonstration award date. To the extent that a change in Federal law, which does not exempt state section 1115 demonstrations, would affect state Medicaid spending in the absence of the demonstration, CMS, in consultation with the state, will incorporate such changes into a modified budget neutrality limit for the Demonstration. The modified budget neutrality limit will be effective upon implementation of the change in Federal law, as specified in law. If the new law cannot be linked specifically with program elements of the Demonstration (e.g., laws affecting sources of Medicaid or SCHIP funding), the State must submit its methodology for complying with the change in law to CMS for approval. The methodology must be consistent with Federal law and in accordance with Federal projections of the budgetary effects of the new law. Should CMS and the state, working in good faith to ensure state flexibility, fail to develop, within 90 days of the effective date of the law, a methodology to revise the without waiver baseline that is consistent with Federal law and in accordance with Federal budgetary projections, a reduction in Federal payments will be made according to the method applied in non-demonstration states.

V. ELIGIBILITY AND ENROLLMENT

1.Screening for Medicaid and SCHIP. Applicants for the demonstration will be screened for Medicaid and SCHIP eligibility. Participants will be offered an informed choice of voluntary enrollment in the direct coverage program for which they are eligible or in premium assistance if it is available. During the demonstration project, eligibility status of participants will be redetermined on a regular basis. FFP will be provided at the Title XIX matching rate for Title XIX eligibles, and at the Title XXI matching rate for Title XXI eligibles.

2.*Simplified Mail-in Application. The State presently uses a mail-in Medicaid and SCHIP application that features simplified eligibility determination. The application must inform applicants that simplified eligibility determinations may result in adverse actions for certain applicants, and must contain instructions on how to request a full eligibility determination from the Illinois Department of Public Aid office or its agents, as applicable. The mail-in application must be submitted to CMS for approval before the implementation date of the demonstration.

3. Enrollment limits. The demonstration is to be phased-in by income level, depending upon available state funding. Any changes to the projected phased-in schedule should be submitted to CMS no later than 90 days prior to the date of implementation of the change(s) for approval by CMS. Within 30 days of receipt, CMS will identify, in writing, all significant issues that are to be addressed by the state, and will work with the state toward a final decision within 60 days. The 60-day period includes a 30-day period in which the state is responding to CMS's written comments and questions on the amendment. The State shall describe the phase-in schedule in the Operational Protocol in Section IX.

4. *Enrollment in Premium Assistance. CMS has given approval through this demonstration for optional eligibles to choose to receive coverage through premium assistance for private or employer-sponsored insurance. Such enrollment is to be voluntary and based on informed choice regarding all implications of choosing premium assistance, including the possibility of reduced benefits and increased cost sharing, and that the title XXI cost sharing limit of five percent on annual, aggregate cost sharing will not apply. Enrollees are to be periodically notified that they may choose direct coverage at any time. In the case of Title XXI-eligible children, families are to be informed that all age-appropriate immunizations in accordance with the recommendations of the Advisory Committee on Immunization Practices (ACIP) are covered. Families will also be told that this coverage is a factor to consider in choosing private or employer-sponsored insurance. The State shall provide information as to where children may receive immunizations and well-baby and well-child services in the event these services are not covered in the employer-sponsored plan or private health plan in which they are enrolled. In the case of title XXI eligibles whose employer or private insurance does not include immunizations, the State agrees to establish a mechanism to reimburse providers for the cost of immunizations. All policies and procedures related to the requirements detailed in this paragraph are to be detailed in the operational protocol. All informing materials related to this requirement are to be submitted to CMS for approval prior to use.

VI. BENEFITS

1. **Premium Assistance.** For optional categories of children and parents who choose to receive coverage through premium assistance, as well as expansion parents who are enrolled in premium assistance, CMS is approving the benefit package available through the private or employer-sponsored insurance company as the benefit package to be delivered. (See discussion in V.4. regarding immunizations and well-baby and well-child services.)

2. **Expansion Parents Not in Premium Assistance.** For expansion parents who do not have premium assistance available, or who choose direct coverage, the benefit package will be the same as for adults in the state's Medicaid program with the exceptions outlined in the State's application, Attachment C.

3. **ICHIP Program.** For those individuals included in the ICHIP program, the

State will provide inpatient, outpatient, physician's surgical and medical services, laboratory and x-ray services, and pharmacy services.

4. **Hemophilia Program.** For those individuals included in the hemophilia program, the State must include a primary care benefit package. Hemophilia services covered also include visits at hemophilia centers, blood derivatives and coagulant factor replacement for use in hospitals, in medical and dental facilities, or at home, outpatient hospital services, physician services, medical supplies and appliances.

VII. COST SHARING

Cost sharing amounts are those submitted in the state's revised HIFA proposal of September 3, 2002. Any changes must be submitted as a waiver amendment.

1. **Premium Assistance.** For optional categories of children and parents who choose to receive coverage through premium assistance, as well as expansion parents, who are enrolled in premium assistance, cost sharing requirements will be set by their private or employer based coverage.

2. **Expansion Parents Not in Premium Assistance**. For expansion parents with incomes at or below 133 percent of the Federal Poverty Level (FPL) who do not choose premium assistance, cost sharing will be the same as for adults in the state's Medicaid program. For expansion parents with incomes above 133 percent of the FPL who do not choose premium assistance, cost sharing will be the same as in the state's SCHIP program. The state's SCHIP program cost sharing for adults will be adjusted to ensure that parents with incomes at or below 133 percent of the FPL do not have higher cost sharing than parents with income above 133 percent of the FPL. This adjusted cost sharing will be detailed in the Operational Protocol.

3. **ICHIP Program.** Premiums vary by gender, age, area of residence and deductible amount. Coinsurance is 20% for preferred providers and 40% for other providers.

4. **Hemophilia Program**. The cost sharing methodology is specified by the State and is to be detailed in the Operational Protocol.

VIII. PROGRAM DESIGN

A. Concurrent Operation

The state's title XIX and XXI state plans, as approved, will continue to operate concurrently with this section 1115 demonstration.

B. Maintenance of Coverage and Enrollment Standards for Children

1. The State shall not close enrollment, institute waiting lists, decrease benefits, increase cost sharing, or decrease eligibility standards with respect to the children covered under its title XXI state plan while the demonstration is in effect.

2. The State shall, throughout the course of the demonstration, continue to show that it has implemented procedures to enroll and retain eligible children for Medicaid and SCHIP.

3. The State will establish a monitoring process to ensure that expenditures for the HIFA amendment do not exceed available title XXI funding (i.e., the title XXI allotment or reallocated funds) and the appropriate state match. The State will use title XXI funds to cover services for the SCHIP and HIFA populations in the following priority order:

    1) Children eligible under the title XXI state plan.
    2) Demonstration population 5
    3) Demonstration population 6
    4) Demonstration population 7
    5) Demonstration population 8

If the state determines that available state or title XXI funding will be exhausted, available title XXI funding will first be used to cover costs associated with the title XXI state plan population and demonstration population 5. The State will not close enrollment, institute waiting lists, decrease benefits, increase cost sharing, or decrease eligibility standards with respect to the children covered under its title XXI state plan while this demonstration is in effect.

The State may also, for any of the demonstration populations under title XIX and XXI eligible for coverage only by virtue of the demonstration

- Lower the federal poverty level used to determine eligibility, and/or
- Suspend eligibility determination and/or intake into the program, or
- Discontinue coverage

Before taking any of the above actions related to the priority system, Illinois will provide 60-day notice to CMS.

IX. OPERATIONAL PROTOCOL

1. *** Prior Approval.** Prior to the implementation date, the State must prepare, and CMS must approve, a single Operational Protocol document representing all policies and operating procedures of the demonstration. The protocol must be submitted to CMS no later than 90 days prior to program implementation. The CMS will respond within 60 days of receipt of the protocol regarding any issues or areas that require

clarification. No Federal Financial Participation (FFP) will be provided for payments under the demonstration until CMS has approved the Operational Protocol. The State must assure and monitor compliance with the protocol. In the event that the desired implementation date is less than 90 days from the date of approval, CMS and the State agree to work in good faith to ensure that the review of the Operational Protocol is completed in a timely fashion in order to allow the State to meet its implementation timeframe.

2. **Changes to the Operational Protocol.** During the demonstration, subsequent changes to demonstration program and the Operational Protocol that are the result of major changes in policy or operating procedures must be submitted for review by CMS. The State must submit a request to CMS for these changes no later than 90 days prior to the date of implementation of the change(s).

3. **Operational Protocol Content.** At a minimum, the protocol must address all of the following areas, plus any additional features of the demonstration referenced in these Special Terms and Conditions or the state's application for the demonstration:

    a) **Organization and Structural Administration.** A description of the organizational and structural administration that will be in place to implement, monitor, and operate the demonstration and coordinate with the Medicaid and SCHIP programs, and the tasks each organizational component will perform. Include details about the organizational components responsible for eligibility, outreach, enrollment, compliance with cost sharing limitations, monitoring, evaluation, and financial management.

    b) **Reporting Items.** A description of the content and frequency of each of the reporting items as listed in Section III of this document.

    c) **Income Limit.** A detailed discussion of the income limits the State will use for the program.

    d) **Eligibility/Enrollment.** A detailed description of all groups eligible for the demonstration; and the processes for eligibility determination and annual redetermination, enrollment and disenrollment, and procedures for ensuring that all participants will be screened and enrolled in the program for which they are eligible or, adequately informed of their voluntary choice of premium assistance if it is available as described in Section V.1. A detailed description of the process and timelines for regularly notifying Medicaid and SCHIP beneficiaries enrolled in private or employer-sponsored coverage of their ability to choose direct coverage at any time and of the implications of their current coverage. The state's outreach, marketing, and staff training strategy will also be detailed, including: information that will be communicated to providers, potential demonstration participants, and state outreach/education/eligibility staff;

types of locations where such information will be disseminated; and the availability of bilingual materials/interpretation services and services for individuals with special needs. The State should also describe how it will review and approve marketing materials prior to their use.

e) **Phase-In Schedule.** Discuss the operational details. Please discuss any process for revising the schedule.

f) **Implementation Schedule.** Please discuss the operational details and provide an implementation schedule.

g) **Premium Assistance.** Describe all details of the premium assistance component of the demonstration, including but not limited to, all elements described in V.4, VI.1., and VII.1. and the state's plan for assuring that rebate recipients are actually enrolled in private or employer-sponsored insurance.

h) **Quality.** Describe the state's overall quality assurance monitoring plan. The plan should include, at a minimum, the following: Quality indicators to be employed to monitor service delivery under the demonstration and the system to be put in place so that feedback from quality monitoring will be incorporated into the program; quality monitoring surveys, and the monitoring and corrective action plans to be triggered by the surveys; and fraud control provisions and monitoring.

i) **Grievances and Appeals.** Provide a description of the grievance and appeal policies that will be in place in the demonstration and how the process will be monitored, with a particular emphasis on complaints related to the premium assistance component and how individuals who choose premium assistance are informed about the use of the state fair hearings process.

j) **Title XXI Financing.** A description of the process for monitoring allotment neutrality, and the procedures for meeting the financial requirements specified in Attachment C. The description should include the state's process for ensuring that care is not interrupted for the approved state plan population or the demonstration populations should the state expend the full amount of the available state or Federal funds during the demonstration period.

k) **Evaluation Design.** Provide a more detailed description of the state's evaluation design included in its revised HIFA proposal of September 3, 2002, including:

- a discussion of the demonstration hypotheses that will be tested;

- outcome measures that will be included to evaluate the impact of the demonstration;
- what data will be utilized;
- the methods of data collection;
- how the effects of the demonstration will be isolated from those other initiatives occurring in the state; and
- any other information pertinent to the state's evaluative or formative research via the demonstration operations.

X. MONITORING

1. *Maintenance of Effort Requirement – Prior to implementation, the State must submit a plan detailing how it will monitor and ensure that the maintenance of effort requirement contained at II.9. is met.

ATTACHMENT A
GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

1. The State will provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. The CMS will provide Federal Financial Participation (FFP) for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in Attachment B (Monitoring Budget Neutrality for the demonstration). Federal financial payment will not be provided for expenditures financed by collections in the form of pharmacy rebates, enrollment fees, or third party liability.

2. **a.** In order to track expenditures under this demonstration, the State will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual. All expenditures subject to the budget neutrality cap will be reported on separate Forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). For monitoring purposes, cost settlements must be recorded on Line 10.b, in lieu of Lines 9 or 10c. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10.c, as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality cap," is defined below in item 2.b.

b. For the purpose of this section, the term "expenditures subject to the budget neutrality cap" will include all Medicaid expenditures on behalf of all demonstration participants as defined in Section II.2 of the Special Terms and Conditions) that are also receiving the services subject to the budget neutrality cap.

c. For each demonstration year a Form CMS-64.9WAIV and/or 64.9PWAIV will be submitted reporting expenditures subject to the budget neutrality cap. All expenditures subject to the budget neutrality ceiling for demonstration eligibles (current and expansion) must be reported. The sum of the expenditures, for all demonstration years reported during the quarter, will represent the expenditures subject to the budget neutrality cap (as defined in 2.b.).

d. Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the demonstration.

e. All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the Form CMS-64 in order to properly account for these expenditures in determining budget neutrality.

f. The procedures related to this reporting process, report contents, and frequency must be discussed by the state in the Operational Protocol (see Section IX).

3. a. For the purpose of calculating the budget neutrality expenditure cap described in Attachment B, the State must provide to CMS on a quarterly basis the actual number of eligible member/months for the Medicaid Eligibility Groups as defined in section 3.c below. This information should be provided to CMS in conjunction with the quarterly progress report referred to in number 1 of Section III. If a quarter overlaps the end of one demonstration year (DY) and the beginning of another, member/months pertaining to the first DY must be distinguished from those pertaining to the second. (Demonstration years are defined as the years beginning on the implementation date, or the anniversary of that day.) Procedures for reporting eligible member/months must be defined in the Operational Protocol (see Section IX).

b. The term "eligible member/months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes three eligible member/months to the total. Two individuals who are eligible for 2 months each contribute two eligible member months to the total, for a total of four eligible member/months.

c. As specified in Attachment B, CMS and the State will develop base year per member per month costs (PMPMs) for each of the Medicaid eligibility groups included in the demonstration, including those who could be made eligible by virtue of Section 1902(r)(2) or Section 1931. The eligibility groups included in the demonstration, for whom separate PMPMs will be developed as specified in Attachment B, are as follows:

MEG 1	Insured Rebate Children Enrolled in premium assistance other than Optional Title XIX children
MEG 2	Insured Rebate Children Who elect direct coverage
MEG 3	Insured Rebate Parents Enrolled in premium assistance
MEG 4	Insured Rebate Parents Who elect direct coverage

MEG 5	Current XIX Optional Children Who may choose premium assistance (rebate) under the demonstration
MEG 6	Current XIX Optional Adults Who may choose premium assistance (rebate) under the demonstration

4. The standard Medicaid funding process will be used during the demonstration. The State must estimate matchable Medicaid expenditures on the quarterly Form HCFA-37. As a supplement to the Form HCFA-37, the State will provide updated estimates of expenditures subject to the budget neutrality cap as defined in 2 c. of this Attachment. The CMS will make Federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. The CMS will reconcile expenditures reported on the Form CMS-64 annually with Federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

5. CMS will provide Federal Financial Participation (FFP) at the applicable Federal matching rate for the following, subject to the limits described in Attachment B:

a. Administrative costs, including those associated with the administration of the demonstration.
b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved State Plan.
c. Medical assistance expenditures made under Section 1115 demonstration authority, including those made in conjunction with the demonstration, net of enrollment fees and premiums, cost sharing, pharmacy rebates, and all other types of third party liability.

6. The State will certify state/local monies used as matching funds for the KidCare Parent Coverage demonstration and will further certify that such funds will not be used as matching funds for any other federal grant or contract, except as permitted by federal law.

ATTACHMENT B
MONITORING TITLE XIX BUDGET NEUTRALITY
FOR THE DEMONSTRATION

The following describes the method by which budget neutrality will be assured under the demonstration. The demonstration will be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the waiver period. This limit will be determined using a per capita cost method. In this way, the State will be at risk for the per capita cost (as determined by the method described below) for Medicaid eligibles, but not at risk for the number of eligibles. By providing FFP for all eligibles, CMS will not place the state at risk for changing economic conditions. However, by placing the state at risk for the per capita costs of Medicaid eligibles, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

For the purpose of calculating the overall expenditure limit for the demonstration, separate budget estimates will be calculated for each year on a demonstration year (DY) basis. The annual estimates will then be added together to obtain an expenditure estimate for the entire demonstration period. The Federal share of this estimate will represent the estimated maximum amount of FFP that the state may receive during the 5-year period for the types of Medicaid expenditures described below. For each DY, the Federal share will be calculated using the FMAP rate(s) applicable to that year.

Base Year Expenditures

The base year expenditure and per capita amounts, and demonstration years trended per capita amounts must be consistent with enforcement of laws and policy statements, including regulations and letters regarding impermissible provider payments, health care related taxes, or other payments; if necessary adjustments must be made. The CMS reserves the right to make adjustments to the budget neutrality cap if any health care related tax that was in effect during the base year, or provider related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of 1903(w) of the Social Security Act.

The base year will be state fiscal year 2002. Base year expenditure and enrollment data (calculated in member months) will be used to calculate base year per capita costs for current eligibles under this demonstration. A base year per capita amount will be established for each Medicaid Eligibility Group. The base year expenditure and enrollment data must be finalized with CMS no later than six months from waiver approval.

This budget neutrality agreements includes optional Medicaid populations that could be added under the State Plan but were not included in current expenditures. These populations include MEGS 1-4 as defined in Attachment A. Since CMS policy precludes access to budget neutrality “savings” from such groups, CMS and the State agree to use

all available data to establish a prospective per capita cap on federal financial risk for these groups based on the actual costs that the population is expected to incur under the waiver. Eligibility groups that are added to the state's program, and incorporated into the demonstration, in response to changes in law or regulation will be treated similarly, i.e., there will be no access to budget neutrality "savings" from the addition of the group. CMS and the State agree that the prospective caps for MEGS 5 and 6 will be based on state fiscal year 2002 experience, as specified above.

Base year expenditures and trended per capita amounts will not be included for Medicaid State Plan amendments submitted after the established base year. All State Plan amendments submitted before or during the base year must be reflected in the base year data finalized with CMS.

Projecting Service Expenditures/Trend Rate

Each demonstration year estimate of Medicaid service expenditures will be calculated as the product of the trended monthly per person cost times the actual number of eligible/member months as reported to CMS by the state under the guidelines set forth in Attachment A number 3.a. If the Demonstration Years do not align with base year or fall beyond the range of years shown the base year must be calculated by pro-rating the agreed-upon annual trend rate for the appropriate number of months.

The trend rate for each all MEGs as defined in Attachment A is 4.00 percent for each year of the demonstration.

Using the trend rates to produce Demonstration Year PMPM cost estimates
If the beginning and the end of the demonstration do not coincide with the base year, the following methodology will be used to produce DY estimates of PMPM cost. Using a monthly equivalent growth rate, the appropriate number of monthly trend factors will be used to convert base year PMPM costs to PMPM costs for the first DY. After the first DY, the annual trend factor will be used to trend forward from one year to the next.

How the limit will be applied

The limit calculated above from the trended service expenditures will apply to actual expenditures for demonstration services, as reported by the state under Attachment A. If at the end of the demonstration period the budget neutrality provision has been exceeded, the excess Federal funds will be returned to CMS. There will be no new limit placed on the FFP that the state can claim for expenditures for beneficiaries and program categories not listed. If the demonstration is terminated prior to the 5-year period, the budget neutrality test will be based on the time period through the termination date.

Expenditure Review

CMS shall enforce budget neutrality over the life of the demonstration, rather than on an annual basis. However, no later than 6 months after the end of each demonstration year, CMS will calculate an annual expenditure target for the completed year. This amount will be compared with the actual FFP claimed by the state under budget neutrality. Using the schedule below as a guide, if the state exceeds the cumulative target, they must submit a corrective action plan to CMS for approval. The State will subsequently implement the approved program.

Year	Cumulative target definition	Percentage
Year 1	Year 1 budget neutrality cap	+8 percent
Year 2	Years 1 and 2 combined budget neutrality cap	+3 percent
Year 3	Years 1 through 3 combined budget neutrality cap	+1 percent
Year 4	Years 1 through 4 combined budget neutrality cap	+0.5 percent
Year 5	Years 1 through 5 combined budget neutrality cap	0 percent

ATTACHMENT C

GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XXI

1. The State shall provide quarterly expenditure reports using the Form CMS-21 to report total expenditures for services provided under the approved SCHIP plan and those provided through the Illinois Demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS will provide Federal Financial Participation (FFP) only for allowable KidCare Parent Coverage Demonstration expenditures that do not exceed the state's available title XXI funding.

2. In order to track expenditures under this demonstration, the State will report demonstration expenditures through the Medicaid Budget and Expenditure System (MBES), as part of the routine quarterly CMS-21 Waiver/CMS-21P Waiver reporting process. Title XXI demonstration expenditures will be reported on separate Form CMS-21, identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made).

    a. All claims for expenditures related to the demonstration (including any cost settlements) must be made within two years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the Form CMS-21.

    b. The standard SCHIP funding process will be used during the demonstration. Illinois must estimate matchable SCHIP expenditures on the quarterly Form CMS-21B. On a separate CMS-21B, the State shall provide updated estimates of expenditures for the demonstration populations. CMS will make Federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-21 quarterly SCHIP expenditure report. CMS will reconcile expenditures reported on the Form CMS-21 with Federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

    c. The State will certify state/local monies used as matching funds for the demonstration and will further certify that such funds will not be used as

matching funds for any other federal grant or contract, except as permitted by federal law.

3. Illinois will be subject to a limit on the amount of Federal title XXI funding that the State may receive on demonstration expenditures during the waiver period. Federal title XXI funding available for demonstration expenditures is limited to the state's available allotment, including currently available reallocated funds. Should the state expend its available title XXI Federal funds for the claiming period, no further enhanced Federal matching funds will be available for costs of the separate child health program or demonstration until the next allotment becomes available.

4. Total Federal title XXI funds for the State's SCHIP program (i.e., the approved title XXI state plan and this demonstration) are restricted to the state's available allotment and reallocated funds. Title XXI funds (i.e., the allotment or reallocated funds) must first be used to fully fund costs associated with the state plan population. Demonstration expenditures are limited to remaining funds.

5. Total expenditures for outreach and other reasonable costs to administer the title XXI state plan and the demonstration that are applied against the state's title XXI allotment may not exceed ten percent of total title XXI expenditures.

6. If the state exhausts the available title XXI Federal funds in a Federal fiscal year during the period of the demonstration, the State will continue to provide coverage to the approved title XXI state plan separate child health program population and the Demonstration Populations with state funds.

7. All Federal rules shall continue to apply during the period of the demonstration that state or title XXI Federal funds are not available. The state is not precluded from closing enrollment or instituting a waiting list with respect to the Demonstration Populations with the exception of demonstration population 5. Before lowering the Federal Poverty Level used to determine eligibility, closing enrollment, instituting a waiting list, decreasing benefits, or increasing cost sharing, the State will provide 60-day notice to CMS.